STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/03/2013

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R000000	This survey was for a State Residential Licensure Survey. Survey Dates: May 1 and 2, 2013. Facility Number: 001132 Provider Number: 001132 AIM Number: N/A Survey Team: Heather Lay, RN - TC Lori Brettnacher, RN Census Bed Type: Residential: 49 Total: 49 Census Payor Type: Other: 49 Total: 49 Sample: 8 Theses State Residential findings are cited in accordance with 410 IAC 16.2. Quality Review completed on 05/03/2013 by Brenda Nunan, RN.	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R000029	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, and record review, the facility failed to ensure a resident who requested a private conversation was treated with respect and dignity during the interview for 1 of 3 residents interviewed (Resident #4). Findings: Resident #4's record was reviewed on 5/1/2013 at 12:00 P.M. Resident #4 had a diagnosis which included, but was not limited to, mental illness. On 5/1/2013 at 12:45 P.M., Resident #4 requested a private conversation. During an interview with Resident #4 on 5/1/2013 at 12:55 P.M., the Director of Nursing (DoN) entered the room, pointed at Resident #4, and stated, "She is not interviewable." A private interview was requested and the DoN left the room. The DoN knocked on the door at 1:00 P.M. and re-entered the room while the interview was in process, without waiting for a response to her knock. The DoN asked the resident if she wanted to talk to her. Resident #4 replied, " I am talking to these girls. "	R000029	The facility will ensure that any and all residents shall be treated with respect and dignity The facility acknowledges this deficiency could potentially affect all residents The facility will ensure this deficiency does not recur by a. the DON in question being informed by the board with the director present that any and all residents are entitled to a private conversation per their request. b. all staff was informed of this as well. ADDENDUM: an inservice is already and currently provided on resident rights which all employees are given. They all sign as well for verification and aknowledgement. The director of nursing was given a written communication of the non-compliance. issues. The changes put into place were making sure the nursing department as well as the rest of the staff are fully aware of the resident rights. Therefore, The inservice is to be given again to the entire staff on June 20, 2013	05/03/2013

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	During an interview on 5/1/2013 at 2:30 P.M., with the Ombudsman present, the DON indicated, she was aware residents had the right to talk to the State Surveyors privately. She further indicated, she was not aware we would be interviewing residents they had identified as non-interviewable.			

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R000033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure a posting of state agencies included a toll free number for filing a complaint of resident abuse, neglect, misappropriation of resident property, and other practices with the Indiana State Department of Health (ISDH). This deficient practice affected 49 of 49 residents residing in the facility. Findings include: On 5/1/13 at 10:45 A.M., tour of the facility was initiated with the Director	R000033	The facility will ensure that the correct info is posted. The facility will ensure this deficiency does not recur by making sure the info always remains posted in the proper locations. The facility obtained the 1-800 number from the surveyors and posted the info immediately.ADDENDUM The office manager with the help of the Director of resident accommodations will monitor these postings on their morning walk thru to ensure continued compliance.	05/03/2013

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	of Nursing [DoN]. At that time, a posting of state agencies was observed at the nurse's station. The posting did not indicate how to contact ISDH or the toll free complaint hotline number. At that time, in an interview, the DoN indicated she would place the toll free number with the posting. On 5/1/13 at 1:00 P.M., in an interview, the facility Owner indicated she was unaware the information needed to be posted. She indicated the local number to the ISDH was posted; however, she would post the required information.			

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R000090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any			

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	subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to report an allegation of abuse to the state agency 1 of 1 allegations of abuse reviewed (Resident #4). Findings: Resident #4's record was reviewed on 5/1/2013 at 12:00 P.M. Resident #4 had a diagnosis which included, but was not limited to, mental illness. During an interview on 5/1/2013 at 12:45 P.M., Resident #4 stated Resident #9 had been " harassed, pushed around, and had money stolen from him. " Resident #4 indicated she reported the incident to the facility. During an interview on 5/2/2013 at 9:40 A.M., the Housekeeping Supervisor (HS), indicated, a few weeks earlier, Resident #4 reported another resident had a gun and feared the resident would " kill	R000090	The facility will ensure that all unusual occurrences are reported to the board. The facility acknowledges all residents do have to potential to be affected. The facility will ensure this does not recur by: a. the facility was unaware that this type of incident needed reported due to the situation that exists with this resident. she is of a specialized population and was treated in an ongoing psych program with her mental health providers which are very aware of the situation and regard it as delousions and hallucinations. b. if the situation had any regard to the thought of abuse, the facility would have immediately reported it as they have always done in the past. c. all staff is already aware and already complies with informing other staff of any unusual behaviors or allegations. d. the facility will keep and continue open communication with staff and residents as it has always maintained. The facility ensure completion should another incident arise.ADDENDUMAn inservice on abuse is currently provided to the entire staff. written	05/10/2013

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	Resident #9. " HS indicated, Resident #4 frequently reported concerns regarding abuse of Resident #9 by other residents. HS indicated allegations made by Resident #4 were not reported due to patterns of reporting and the resident's mental illness During an interview on 5/2/2013 at 2:00 P.M., the owner indicated she was aware of the allegation made by Resident #4 and indicated the allegation had not been reported. On 5/1/2013 at 12:30 P.M., the owner provided an undated document titled, "Resident Abuse Policy." This document indicated, ". . . The facility shall ensure that all alleged violations involving mistreatment, neglect, abuse or injuries of unknown source and misappropriation of resident's property are reported immediately to administrator and the State survey and certification agency. . . ."		aknowledgement is obtained for verification purposes. This is provided upon hire and yearly within the regular inservice schedule.The changes put into place to ensure the deficiency does not recur are as stated above. to keep open communication with entire staff for resident behavior monitoring. to be better advised that this issue is reportable. to report any occurence should one arise in the future.the facility will still follow the exact protocol of involving the mental health provider also.	

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R000151	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure 1 of 1 pets reviewed for required immunizations was vaccinated. This deficient practice affected 1 of 1 resident reviewed for up to date pet vaccinations [Resident #6]. Findings include: On 5/1/13 at 10:50 A.M., Resident #6 was observed sitting outside his room with the door open. Near the doorway, inside his room, a plate of cat food was observed and a cat was observed outside on the facility lawn. In an interview, Resident #6 indicated the cat was his and he kept the cat in his room at times; however, he indicated the cat liked to be outside when it was nice out. On 5/1/13 at 11:10 A.M., in an interview, the Director of Nursing [DoN] indicated the facility did not have any vaccination records on the cat because it was a stray cat. She indicated all the residents enjoyed the cat and Resident #6 had been told	R000151	The facility will ensure the cat gets vaccinated. The owner was unaware the cat was let into the residents room. He has taken the stray on as his pet with out knowledge of the admin. The vaccination process is being researched for free or minimal money because the resident has no money to do so and the facility is state funded. The resident accommodations director has found this process before for a private resident and will continue for this resident. As far as the pet policy, this is for our private residents only. Admin informed housekeeping that they are in and out of the rooms daily. They should have notified someone of the fact the resident had taken a stray in with regard to the food bowls. Addendum.the facility gave a date of 6/28/13 for this to be corrected so therefore, it is not done yet.The facility does not have a pet policy for the state building, only the private residents. Therefore, there should not have been a pet inside the annex building. So , compliance should never be an issue in the future.The system put into place to monitor this happening in the future was to make sure housekeeping reports to their	06/28/2013

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	not to keep the cat in his room. On 5/2/13 at 9:50 A.M., the Director of Operations provided a pet policy, dated 8/15/2000. The pet policy included, but was not limited to, "Pets are allowed upon approval of the Owner...The resident must be able to take proper care of his/her pet.. The pet must have had all appropriate shots...."		supervisor if said deficiency would ever occur again. The housekeeping super will monitor her employees on a daily basis with daily cleaning and report sheets. the Director of resident accommodations is taking care of the coordination of the vaccinations for the pet in question.	

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R000155	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview, the facility failed to ensure waste was contained in a dumpster for 2 of 2 observations. Findings: During observations made on 5/1/2013 at 10:00 AM. and 2:35 P.M., the facility's trash dumpster was observed with the lid open, filled with trash bags and debris, and a bag of trash sitting next to the dumpster on the ground. During an interview on 5/2/2013 at 3:00 P.M., the owner indicated the trash should be placed in the dumpster and not on the ground around the dumpster.	R000155	The facility will ensure that the garbage disposal dumpster lids remain closed. The facility will ensure this deficiency does not recur by informing the staff of said practice of closing the lids of dumpsters and putting trash inside of dumpster instead of on the ground. The facility informed staff to stop being lazy, plain and simple. The dietary and housekeeping staff were in a fail re: this problem The facility informed all staff in writing that they will be written up if they preform this deficient practice.AddendumThe inservice was provided on june5, 2013. this was signed for also as aknowledgement.The changes put into place were for as stated above, the dietary and housekeeping staffs shall be compliant at all times. the housekeeping super and the dietary super shall monitor their staff throughout their daily duties and responsibilities.	05/31/2013

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R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to evaluate the needs of a resident with a known significant change in condition. This deficient practice affected 2 of 8 residents reviewed for evaluation of needs [Residents #6 and #7]. Findings include: 1. On 5/1/13 at 11:55 A.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, mental illness, and coronary artery disease. A physician's orders, dated 3/25/13, indicated, " ...Physical Therapy, Occupational Therapy, and Skilled Nursing to evaluate and treat related to self care deficit, fatigue with activities of daily living, decline in condition, education about dietary needs, pain control..." A nurse's notes, dated 3/25/13, no	R000214	The facility acknowledges this deficiency has the potential to affect all residents. The facility will ensure this does not recur by : a. The don was informed she needed to be more effective in her job as to charting properly and record review. b. the don was given a complete written reprimand as this practice is completely unacceptable. c. any time a change of condition occurs the don must evaluate the resident, or if the resident is sent to the er, the don must document. if new orders are returned, the don must evaluate. d. a new form was created by the owner for any re admit from hosp or nursing home or rehab for evaluation. e. this form will be done from now on out f. the qma's were also informed of this deficiency and were told to keep open communication with the admin and don. The admin will monitor the don.AddendumThe mgmt. monitors the don on a daily basis. The nursing staff as well as resident accommodations staff does a report meeting every day to ensure everyone is aware of	05/31/2013

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	time, indicated, " ...Home Health related to decrease in condition...." A "Monthly Summary," dated 3/3/13, indicated Resident #6 was independent with transfers and dressing. A "Monthly Summary," dated 4/7/13, indicated Resident #6 was independent with transfers and dressing. There was no documentation of an evaluation related to Resident #6's significant change. On 5/1/13 at 2:30 P.M., Resident #6's evaluation was requested from the Director of Nursing [DoN]. At that time, she indicated monthly summaries had been completed. On 5/1/13 at 3:00 P.M., in an interview, the DoN indicated the facility was unable to provide documentation of an evaluation for the decline in condition, identified in the physician orders, dated 3/25/13, for Resident #6. 2. On 5/1/13 at 12:15 P.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, major depression, hemiplegia,		any changes of any residents regarding their condition, behavior or whereabouts. A written report is provided daily with a census to the mgmt.	

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	hypertension, and coronary artery disease. A "Monthly Summary," dated 3/9/13, indicated, "...Locomotion: Ambulates with a limp due to hemiplegia...." An untimed nurse ' s note, dated 3/21/13, indicated, "...Sent [Resident #7] to ER [emergency room] for evaluation of RLE [right lower extremity]...." A nurse's notes, dated 3/21/13 at 7:30 P.M., indicated, "...Res [Resident #7] with new order for Augmentin [antibiotic]...." An undated progress note, indicated, "...Patient [Resident #7] noted with lower extremity edema and redness to right lower extremity...Right lower extremity cellulitis...." The record did not indicate an evaluation of needs had been completed for Resident #7 ' s swelling in the lower extremities On 5/1/13 at 2:30 P.M., the Director of Nursing [DoN] indicated the facility completed a "Monthly Summary" on each resident. She indicated when Resident #7 ' s monthly summary was completed on 3/9/13, the resident did			

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	not have swelling of the lower extremities. She indicated she did not complete an evaluation of needs for the change in condition that required an emergency room evaluation on 3/21/13.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to have residents sign the agreed upon service plan. This deficient practice affected 5 of 8 residents reviewed for signed service plans [Residents #6, 7, 5, 4, and 3].	R000217	The facility had the residents sign the physicians order sheet because that was the agreed upon solution with a survey team upon past survey. The facility did not come up with this on their own. The facility will now institute the monthly summary into this process as discussed with current survey team. a signature line will	06/28/2013

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		A. BUILDING 00 B. WING	05/03/2013

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	Findings include: 1. On 5/1/13 at 11:55 A.M., Resident #6's record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, mental illness, and coronary artery disease. Resident #6's record failed to contain documentation of a signed service plan which indicated services offered. 2. On 5/1/13 at 12:15 P.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, major depression, hemiplegia, hypertension, and coronary artery disease. Resident #7's record failed to contain documentation of a signed service plan which indicated services offered. 3. On 5/1/13 at 12:55 P.M., Resident #5's record was reviewed. Diagnoses included, but were not limited to, atypical psychosis, constipation, and schizophrenia. Resident #5's record failed to contain documentation of a signed service plan which indicated services offered. 4. On 5/1/13 at 1:00 P.M., Resident		be added to monthly summaries as well as a page and space for comments re changes in condition or need for re evaluation. the next monthly summaries to be done for June shall include these changes. The nursing staff will review, revise and discuss changes with the resident. The residents shall then sign the summary. The don was given orders to ensure she completes this process Although these are only required every 6months or if a change occurs, the facility will continue to do these monthly summaries as we feel it is a better way to utilize and obtain services if needed for our residents. The entire nursing staff will communicate and report to don and admin to ensure this deficiency does not recur.	

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	#4's record was reviewed. Diagnoses included, but were not limited to, falls, hiatal hernia, chronic obstructive pulmonary disease, schizophrenia, and manic depression. Resident #4's record failed to contain documentation of a signed service plan which indicated services offered. 5. Resident #3's record was reviewed on 5/1/2013 at 11:00 A.M. Resident #3 had diagnoses which included, but were not limited to, anxiety, stress incontinence, and borderline personality disorder. Resident #3's record failed to contain documentation of a signed service plan which indicated services offered to her. On 5/1/13 at 2:30 P.M., the Director of Nursing [DoN] indicated the facility used the resident's recapitulation [physician's orders recap] for each month as the service plan and had each resident sign the recap monthly. She indicated the monthly summary was a tool used to assess residential service needs; however, residents were not required to sign. On 5/2/13 at 3:30 P.M., in an			

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	interview, the facility Owner indicated the facility should have utilized a "Care Plan [Agreed Services]" for each resident. She indicated the care plan should have been updated every 6 months or with a significant change of condition and indicated each resident should have signed the plan as acknowledgment of the services provided to them by the facility.			

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure opened containers of food were labeled with an open date and/or a use by date for 1 of 1 food storage observation. This deficient practice had the potential to affect 49 of 49 residents who consumed food from the kitchen. During observations made on 5/1/2013 at 10:40 A.M., with the Dietary Manager (DM) present, the following food products, stored in the kitchen for resident use, were observed in open containers without a method to identify when they were opened and/or a use by date: 1. A bag of opened tater tots 2. A bag of opened corn on the cob 3. A package of opened bacon. 4. An opened container of ranch dressing. 5. A plastic bag which contained baked sweet potatoes. 6. A plastic bag which contained baked potatoes. 7. An opened bag of sweet and sour	R000273	The facility shall ensure that all food handling is within the safe handling standards. The dietary manager immediately corrected the deficiency after tour of surveyors. the surveyors were informed. The dietary manager also immediately wrote and inservice for her staff and gave a copy to the surveyors. the facility will ensure that all food is properly labeled and dated upon opening. The kitchen was given a supply of labels and sharpies to properly label.AddendumThe dietary super immediately inserviced her employees that day when the deficiency occurred. She provided the team with the exact inservice. The inservice contained the proper methods of food labeling and safe handling standards. The dietary super will monitor her employees on a daily basis by checking dry and cold food storage to ensure they are not deficient.	05/03/2013

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	chicken. 8. An opened bag of ground beef. 9. An opened bag of sausage patties. 10. An opened bag of hamburger patties. 11. An opened bag of English muffins. 12. An opened bag of barbeque pork ribs. During an interview on 5/1/2013 at 10:40 A.M., the Dietary Manager indicated, the items were not labeled because the marker used would not stay on the plastic bags and indicated the facility went through the food so quickly it was not necessary to label the food. A policy titled, "Proper Storage of Foods", provided by the owner on 5/1/2013 at 1:04 P.M., indicated, "...Once the product has been opened, it is necessary to date and label the product showing the date it was placed back into storage...There should not be anything opened in the refrigerator for more than 3-5 days...."			